STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

SETTLEMENT BETWEEN COST AND PAYMENT

Provider Name		
Provider Number Period:From To		
DETERMINATION OF ALLOWABLE COST AND REIMBURSEMENT		AMOUNT
1. FQHC Medicaid Rate per Visit (Form 6, Line D7)		
2. FQHC Medicaid and Medicare/Medicaid Crossover Visits During the Reporting Period		
3. Gross Costs for Medicaid including Crossovers (Line 1 Multiplied by Line 2)		
4. Less:Payments by Medicare to FQHC for Crossover Visits		< >
5. Less: Payments by Medicaid to FQHC During the Reporting Period For:		
a) Core Service Visit Rate Reimbursement		
b) Dental and Optometric		
c) Off-site Services		
d) Other		
e) Total (Sum of (a) through (d))		< >
6. Less: Co-Payments made by Medicaid recipients		< >
7. Less: Other Third Party Liability Source Payments		< >
8. BALANCE DUE <To> or From Medicaid (Line 3 less Lines 4, 5(e), 6 and 7)		

FORM 7

TN 93-09 DATE RECEIVED 6-30-93
SUPERSEDES DATE APPROVED 2-18-93
TN 90-08 DATE EFFECTIVE 6-30-93

STATE OF MISSISSIPPI
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FEDERALLY QUALIFIED HEALTH CENTERS

STATEMENT OF REVENUES

Provider Name		
Provider Number Period: From	To	
DESCRIPTION	Column 1 PER GENERAL LEDGER	Column 2 ADJUSTMENT TO FORM 4 COLUMN 7
1. Patient Revenues		
2. Less - Allowances and Discounts on Patients' Accounts		
3. Net Patient Revenues		
4. Total Operating Expenses (Form 4, Line 6, Column 4)		
5. Net Income from Services to Patients		
OTHER INCOME		
6. Contributions, Gifts, Grants, etc.		
7. Interest Income		
8. Medicare Part B Income		
Nursing Supplies		
Other Ancillary Services Revenue		
11. Other Income (Attach Schedule)		
12. Oxygen (Inhalation Therapy) Revenue		
13. Pharmacy Revenue		
14. Rental Income		
15. Speech Therapy Income		
16. State Appropriations		
17. Vending Machines Revenue		
18. Total Other Income		
19. Net Income (Total of Lines 5 and 18)	$	$

TN NO 90-08
SUPERSEDES
TN NO NEW

DATE RECEIVED SEP 26
DATE APPROVED 11/2/92
DATE EFFECTIVE
AUG

STATE OF MISSISSIPPI
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DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

FQHC TRANSACTIONS WITH RELATED ORGANIZATIONS

Provider Name		
Provider Number	Period: From	To

I. Are any costs included in the allowable costs on Form 4 a result of transactions with a related organization as defined in HIM-15, Chapter 10?

YES _____ NO _____
(If yes, compete Section II. and III. below)

II. Costs incurred as a result of transactions with related organizations:

Form Number	Line Number	Name of Related Organization	Transaction Amount	Cost to Related Organization	Amount in Excess of Cost*

* Adjustment to expense should be made to the appropriate line on Form 4.

III. Name and percentage of ownership in the related organization:

Name of Owner	Name of Related Organization	Percent of Ownership

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SCHEDULE OF FIXED ASSETS AND DEPRECIATION

Provider Name				
Provider Number Period: From		To		
Description of Property	Original Cost	Medicaid Basis	Ending Accumulated Depreciation	Current Period Expense
Land				
Buildings and Improvements				
Leasehold Improvements				
Furniture, Fixtures and Equipment				
Vehicles				
Other (Specify)				
TALS				

SPECIFY ANY ASSETS INCLUDED ABOVE THAT ARE NOT RELATED TO PATIENT CARE

PLEASE NOTE: A copy of the provider's depreciation schedule MUST be attached to the cost report. The depreciation schedule MUST BALANCE with the schedule above.

FORM 10

Transmittal 90-08

TN NO	90-08	DATE RECEIVED	SEP 28 1992
SUPERSEDES		DATE APPROVED	11/12/92
TN NO	NEW	DATE EFFECTIVE	AUG 2[illegible]